Carelon Behavioral Health
Policy and Procedure Addendum

Title:		Policy and Procedure number:	
Out-of-State Medicaid Reimbursement		NM 306 A	
Responsible department:	**Author:**	**Approver:**	
Network Management	Rosy Murphy	Nicole Nole, Staff VP Network - National	
Original effective date:	**Date of policy retirement:**	**Last revision date:**	**Last reviewed/ approval date:**
4/10/2010	N/A	03/25/25	03/25/25
Applicability			
☐ Commercial (incl. exchange) ☐ Medicare ☒ Medicaid (incl. grants)	Policy applies to: Carelon Behavioral Health Policies and Procedures cover the operations of all entities within the Carelon Behavioral Health corporate structure, including but not limited to Carelon Behavioral Health Strategies, LLC, Carelon Behavioral Health of California, Inc., Carelon Behavioral Health, Inc., and Carelon Behavioral Care, Inc.		
Regulatory information			
Resources and references			
Federal or state regulations and/or accreditation requirements:	42 CFR 422.105 and 422.111 Deficit Reduction Act (DRA) of 2005, Section 6085 Emergency Medical Treatment and Labor Act (EMTALA) Section 1867 of the Social Security Act		

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I. Scope

Review of the workflow process after the Out of Network (OON) service(s) has been clinically approved based on medical necessity under the Medicaid member's benefit plan and the out of network authorization has been granted for a designated length of time.

II. Addendum Specific Content

Exhibit A: Out-of-State Medicaid Reimbursement

Professional reimbursement	**Facility reimbursement**
Home State Medicaid rates	Home State Medicaid rates

A. When a Medicaid member is seen by a professional in a non-home state and a claim is submitted, the provider must accept the Medicaid fee schedule that applies to the member's

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home state. Billing an out of state Medicaid member for an amount between the Medicaid-allowed amount and charges for Medicaid services is specially prohibited by Federal Regulations 42 CFR 447.15.

B. If services are provided that are not covered by Medicaid to a Medicaid member, these services will not be covered. A Medicaid member can only be billed for a non-covered service if a written approval was obtained prior to services rendered.

C. When a Medicaid member is seen by a facility in a non-home state and a claim is submitted, the provider must accept the Medicaid reimbursement methodology & rates established by the home state for out of state services. Billing an out of state Medicaid member for an amount between the Medicaid-allowed amount and charges for Medicaid services is specially prohibited by Federal Regulations 42 CFR 447.15.

III. References

Referenced Policies
CUR 102 Single Case Agreements
CUR 110 Authorizations to Out-of-Network Providers QM 4
Member Safety Program
Claims 44 Emergency Services Policy

IV. Revision history

Version number:	Approval date:	Description of change(s):
8	09/12/23	New Format
9	03/28/24	Annual Review. No changes
10	03/25/25	Annual Review. Wordsmithing.